



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS HEALTH ALLIANCE

Respondent Name

INDEMNITY INSURANCE COMPANY
OF NORTH AMERICA

MFDR Tracking Number

M4-18-0432-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We realize this was a Q1 but it was not billed with any of the status indicators S T U or V and should have had a payment."

Amount in Dispute: \$118.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "When multiple codes are billed under the same APC, only one code is paid, and the other code is considered bundled in that payment, and there is no separate payment."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 2, 2016	Outpatient Hospital Services	\$118.48	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
 - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from <http://www.cms.gov>.

Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent.

Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure codes 73030 and 73502 have status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are bundled with E&M code 99284, billed on the same claim.
 - Procedure code 99284 has status indicator J2 (hospital, clinic or emergency visit including observation/critical care) subject to composite payment if certain other services are billed in combination. As no other qualifying services were billed, this code is not paid as a composite; it is assigned APC 5024, which, per OPPS Addendum A, has status indicator V. Note that the status indicator for assigned APC code 5024 supersedes the J2 status indicator above, and because of this V status, all Q1 (STV-packaged) status procedure codes billed on the claim are packaged with the visit. The OPPS Addendum A rate is \$326.99, which is multiplied by 60% for an unadjusted labor-related amount of \$196.19, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of \$188.70. The non-labor related portion is 40% of the APC rate, or \$130.80. The sum of the labor and non-labor portions is \$319.50. The cost of services does not exceed the fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific amount of \$319.50 is multiplied by 200% for a MAR of \$639.00.
2. The total recommended payment for the services in dispute is \$639.00. The amount previously paid by the insurance carrier is \$755.66. No additional payment is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	December 8, 2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.